LABORATORY EXAMINATION(S) REQUESTED:

☐ **AN**timicrobial Susceptibility ☐ **IS**olation
☐ **HI**stology ☐ **SE**rology (Specific Test) _____
☐ **ID**entification ☐ **OT**her (Specify) _____

CATEGORY OF AGENT SUSPECTED:

☐ **BA**cterial ☐ **RI**ckettsial
☐ **VI**ral ☐ **PA**rasitic
☐ **FU**ngal ☐ **OT**her (Specify) _____

SPECIFIC AGENT SUSPECTED:	OTHER ORGANISM(S) FOUND:	ISOLATION ATTEMPTED?	NO. OF TIMES ISOLATED:	NO. OF TIMES PASSED:	SPECIMEN SUBMITTED IS:
		☐ YES ☐ NO			☐ Original Material ☐ Mixed Isolate ☐ Pure Isolate

DATE SPECIMEN TAKEN: ___/___/___ ___ ___ (MO DA YR)

ORIGIN: ☐ **HU**man ☐ **FO**od ☐ **SO**il ☐ **AN**imal (Specify) _____ ☐ **OT**her (Specify) _____

SOURCE OF SPECIMEN:

☐ **BL**ood ☐ **CS**F ☐ **WO**und (Site) _____
☐ **GA**stric ☐ **HA**ir ☐ **EX**udate (Site) _____
☐ **SE**rum ☐ **SK**in ☐ **TI**ssue (Specify) _____
☐ **SP**utum ☐ **ST**ool
☐ **UR**ine ☐ **TH**roat ☐ **OT**her (Specify) _____

SUBMITTED ON:

☐ **ME**dium _____
☐ **AN**imal _____
☐ **TI**ssue Culture (Type) _____
☐ **EG**g ☐ **OT**her (Specify) _____

SERUM INFORMATION:

	MO DA YR		MO DA YR
☐ **AC**ute	___ ___/___ ___/___ ___ ___ ___	☐ **S3**	___ ___/___ ___/___ ___ ___ ___
☐ **CO**nvalescent	___ ___/___ ___/___ ___ ___ ___	☐ **S4**	___ ___/___ ___/___ ___ ___ ___
		☐ **S5**	___ ___/___ ___/___ ___ ___ ___

IMMUNIZATIONS:

	MO YR
(1.) _____	___ ___/___ ___ ___ ___
(2.) _____	___ ___/___ ___ ___ ___
(3.) _____	___ ___/___ ___ ___ ___
(4.) _____	___ ___/___ ___ ___ ___

TREATMENT: **DRUGS USED** ☐ None

	DATE BEGUN MO DA YR	DATE COMPLETED MO DA YR
(1.) _____	___ ___/___ ___/___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___
(2.) _____	___ ___/___ ___/___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___
(3.) _____	___ ___/___ ___/___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___

EPIDEMIOLOGICAL DATA:

☐ **SI**ngle Case ☐ **SP**oradic ☐ **CO**ntact ☐ **EP**idemic ☐ **CA**rrier

Family Illness _____

Community Illness _____

Travel and Residence (Location)

☐ **Foreign** _____

☐ **USA** _____

Animal Contacts (Species) _____

Anthropod Contacts: ☐ None ☐ Exposure Only ☐ Bite

Type of Anthropod: _____

Suspected Source of Infection: _____

SIGNS AND SYMPTOMS:

☐ **FE**ver
Maximum Temperature: _____
Duration: _____ Days
☐ **CH**ills

SKIN:

☐ **MA**culopapular
☐ **HE**morrhagic
☐ **VE**sicular
☐ **E**rythema **N**odosum
☐ **E**rythema **M**arginatum
☐ **OT**her

RESPIRATORY:

☐ **RH**initis
☐ **PU**lmonary
☐ **PH**aryngitis
☐ **CA**lcifications
☐ **O**titis **M**edia
☐ **PN**eumonia (type)
☐ **OT**her

CARDIOVASCULAR:

☐ **MY**ocarditis
☐ **PE**ricarditis
☐ **EN**docarditis
☐ **OT**her

GASTROINTESTINAL:

☐ **DI**arrhea
☐ **BL**ood
☐ **MU**cous
☐ **CO**nstipation
☐ **AB**normal Pain
☐ **VO**miting
☐ **OT**her

CENTRAL NERVOUS SYSTEM:

☐ **HE**adache
☐ **ME**ningismus
☐ **MI**crocephalus
☐ **HY**drocephalus
☐ **SE**izures
☐ **CE**rebral Calcification
☐ **CH**orea
☐ **PA**ralysis
☐ **OT**her

MISCELLANEOUS:

☐ **JA**undice
☐ **MY**algia
☐ **PL**eurodynia
☐ **CO**njunctivitis
☐ **CH**orioretinitis
☐ **SP**lenomegaly
☐ **HE**patomegaly
☐ **LI**ver Abscess/cyst
☐ **LY**mphadenopathy
☐ **MU**cous Membrane Lesions
☐ **OT**her

STATE OF ILLNESS:

☐ **SY**mptomatic
☐ **AS**ymptomatic
☐ **SU**bacute
☐ **CH**ronic
☐ **DI**sseminated
☐ **LO**calized
☐ **EX**traintestinal
☐ **OT**her

PREVIOUS LABORATORY RESULTS/OTHER CLINICAL INFORMATION: (Information supplied should be related to this case and/or specimen(s) and relative to the test(s) requested.

CDC NUMBER

UNIT	FY	NUMBER	SUF.

Justification must be completed by State health department laboratory before specimen can be accepted by CDC. Please check the first applicable statement and when appropriate complete the statement with the ⋆.

1. Disease suspected to be of public health importance. Specimen is:
   (a) ☐ from an outbreak. (b) ☐ from uncommon or exotic disease.
   (c) ☐ an isolate that cannot be identified, is atypical, shows multiple antibiotic resistance, or from a normally sterile site(s) (d) ☐ from a disease for which reliable diagnostic reagents or expertise are unavailable in State.
2. ☐ Ongoing collaborative CDC/State project.
3. ☐ Confirmation of results requested for quality assurance.

⋆Prior arrangement for testing has been made.
Please bring to the attention of:

(Name): _____

Completed by:

_____

Date: __ __/__ __/__ __ __ __

Name, Address and Phone Number of Physician or Organization:

STATE HEALTH DEPARTMENT LABORATORY ADDRESS:

STATE OF HAWAII
DEPARTMENT OF HEALTH/STATE LABS DIVISION
2725 WAIMANO HOME ROAD
PEARL CITY, HAWAII 96782

STATE HEALTH DEPT. NO.: _____

DATE SENT TO CDC: (MM/DD/YYYY) __ __/__ __/__ __ __ __

PATIENT IDENTIFICATION: (Hospital No.) _____

NAME: (LAST, FIRST, MI) _____

BIRTHDATE: (MM/DD/YYYY) __ __/__ __/__ __ __ __

SEX: ☐ MALE ☐ FEMALE

CLINICAL DIAGNOSIS: _____

ASSOCIATED ILLNESS: _____

DATE OF ONSET: (MM/DD/YYYY) __ __/__ __/__ __ __ __

FATAL? ☐ YES ☐ NO

(FOR CDC USE ONLY)		CDC NUMBER		DATE RECEIVED
UNIT	FY	NUMBER	SUF	MO DA YR
				__ __/__ __/__ __ __ __

REVERSE SIDE OF THIS FORM MUST BE COMPLETED

THIS FORM MUST BE EITHER PRINTED OR TYPED
PLEASE PREPARE A SEPARATE FORM FOR EACH SPECIMEN

D.A.S.H.

DATE REPORTED
MO DA YR
___ ___/___ ___/___ ___ ___ ___

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Comments:

D	6	5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
Center for Infectious Diseases
Atlanta, Georgia 30333

CENTERS FOR DISEASE CONTROL AND PREVENTION

The Centers for Disease Control (CDC), an agency of the Department of Health and Human Services, is authorized to collect this information, including the Social Security number (if applicable), under provisions of the Public Health Service Act, Section 301 (42 U.S.C. 241). Supplying the information is voluntary and there is no penalty for not providing it. The data will be used to increase understanding of disease patterns, develop prevention and control programs, and communicate new knowledge to the health community. Data will become part of CDC Privacy Act system 09-20-0106, "Specimen Handling for Testing and Related Data" and may be disclosed: to appropriate State or local public health departments and cooperating medical authorities to deal with conditions of public health significance; to private contractors assisting CDC in analyzing and refining records; to researchers under certain limited circumstances to conduct further investigations; to organizations to carry out audits and reviews on behalf of HHS; to the Department of Justice in the event of litigation, and to a congressional office assisting individuals in obtaining their records. An accounting of the disclosures that have been made by CDC will be made available to the subject individual upon request. Except for permissible disclosures expressly authorized by the Privacy Act, no other disclosure may be made without the subject individual's written consent.